
HIPAA Version 5010 Tips

Billing Provider Address

With 5010, the Billing Provider Address you use on claims must be a physical address. You can no longer use PO Box and lock box addresses as a billing provider address. This rule applies to professional, dental and institutional claim formats. However, you can still use a PO Box or lock box address as your location for payments and correspondence as long as you report this location as a pay-to address. The pay-to provider address is only needed if it is different than that of the billing provider.

You should work with your software vendor to ensure the correct addresses are captured and inserted in the necessary locations on your claim submission.

Nine Digit ZIP Codes

With 5010, you must submit a full 9-digit ZIP code when reporting billing provider and service facility locations. An easy way to determine the 4-digit extension to your standard ZIP code is to look it up on the U.S. Postal Service's ZIP Code Lookup Tool, which can be accessed through the following link <http://ZIP4.usps.com/zip4/welcome.jsp>. Work with your software vendors to ensure they can capture the full nine digits for the billing provider and service facility addresses.

Older Claim Formats

As of July 1, 2012, MaineCare Services only accepts electronic claims submitted in a 5010 format. As of July 1, 2012 all claims must be submitted in a 5010 format or they are rejected.

Drug Reporting

With 5010, professional claims for injectable medications must include additional drug information and qualifiers.

Historically, you were required to submit a HCPCS code as the service-line procedure along with the total charge and units of service. With 5010, you are now required to also submit the National Drug Code (NDC) Drug Quantity and Composite unit of measure. The NDC number is used to identify a specific drug.

When submitting service-line drug charges, you should work with your software vendors to ensure that the drug quantity and unit of measure can be submitted. Claims that include an NDC and do not include this information will be rejected.



Compound Drug Claims

The 4010 standards made it difficult to select a single HCPCS code for a compound injectable medication because each ingredient pointed to a different HCPCS code. With 5010, all ingredients that make up a compound prescription must be identified on the claim and a unique HCPCS must be assigned to each ingredient. You will be required to enter separate lines of service for each HCPCS code. As with single ingredient drugs, you must also include your service line charge for each ingredient, the service line associated units, the NDC number, the NDC Drug Quantity, and the Composite unit of measure.

You should work with your software vendors to determine if the product supports these and other drug entry changes.

National Drug Code

With 5010, professional claims for injectable medications must include additional drug information and qualifiers, such as the National Drug Code (NDC) number, which is used to identify a specific drug.

You can find the 11-digit NDC number printed on the drug package in a 5-4-2 format. The first five digits of the NDC identify the drug manufacturer. The next four digits identify the specific product. The last two digits identify the package size. If the segments do not have the appropriate number of digits, you will need to add zeros at the beginning of the segment. For example, if the package number is 1234-123-12, you will need to add zeros at the beginning of the segments to reach the required number of digits for the 5-4-2 format (01234-0123-12). When entering the NDC number in the service-line, you will enter all 11 digits without hyphens (01234012312).

If you submit service-line drug charges you should work with your software vendors to ensure that the NDC information can be submitted in your claims.

Ambulance Claims

In 5010, ambulance suppliers who submit medical transportation claims will be required to report the pick-up and drop-off locations for ambulance transport. With 4010, there were no dedicated fields for this information, but now it can be reported at the claim level (5010 loops: 2310E and 2310F) and service line level (5010 loops: 2420G and 2420H). With 5010 a new segment (2400 QTY) is required to report the number of patients transported in the same vehicle for ambulance or non-emergency transportation services. Please remember, two digit modifiers are also required.

With 5010, a diagnosis code must be on all professional electronic claims, including ambulance and transportation claims. For ambulance or transportation claims where the diagnosis is unknown, use code 780.99 "Other General Symptoms".

You should work with your software vendors to ensure your billing systems are able to capture and report this information on your electronic claims to avoid claims rejection.

Line Item Control Number

The line item control number segment is still not required with 5010 but if you use one, the line item control number for each line of service, for each patient, is now required to be unique. In addition, MaineCare Services is required to return the line item control number in the 835 electronic remittance advice (ERA) transaction when the provider includes it in the original electronic claim or when they have split the claim or line item. This unique line item control number within the ERA gives you the capability to automatically post by service line.

If you send line item control numbers, you should work with your software vendors to verify that their systems can create a unique line item control for each line of service.

Health Care Diagnosis Codes for Professional Claims

One of the main purposes of 5010 is to support the upcoming change to ICD-10 diagnosis and procedure codes. On April 17, 2012, the Department of Health and Human Services (HHS) published a proposed rule that would delay the compliance date for ICD-10 from October 1, 2013, to October 1, 2014.

In order to prepare for ICD-10, 5010 requires a diagnosis code on all claims. The maximum number of diagnosis codes was increased from eight in 4010 to twelve in 5010. You can report twelve diagnosis codes at the claim level. However, you can only point or link four codes to a specific service at the service line level.

Institutional Claim Information Segment

With 5010, the Institutional Claim Code segment, which includes the Admission Type Code and the Patient Status Code, will be required on all institutional claims in 5010. With 4010, this was only required for inpatient visits.

In addition, the “Admission Type Code” has been changed to “Priority (Type) of Admission or Visit”, which you will use to indicate the source of a patient’s admission. Claims you submit in 5010 format will be rejected if a “Priority (Type) of Admission or Visit” value is not entered.

The “Patient Status Code,” which indicates the discharge status of the patient at the end of the statement coverage period, is now required on all claims. Claims you submit in 5010 format will be rejected if a “Patient Status Code” value is not entered in loop 2300, segment CL103.

You should work with your software vendor to ensure your billing systems are able to capture and report this information on your electronic claims to avoid claims rejection.

Attending Provider for Institutional Claims

With 5010, you are required to include the “Attending Provider” on all institutional claims other than non-scheduled transportation claims. All providers, including Private Non-Medical Institution (PNMI) providers, must use a Type 1 NPI in this field to avoid claims rejection. The Attending Provider does not need to be enrolled in MaineCare.

With 4010, listing the “Attending Provider” (the individual who has overall responsibility for the patient’s medical care and treatment reported in the claim) was only required for inpatient claims (ANSI Loop 2310A on the 837I or Field Number 76 on the UB-04).

5010 Editing for Not Otherwise Classified (NOC) Codes

When using Not Otherwise Classified (NOC) procedure codes you are required to submit an additional description in the SV101-07 (2400 loop) for ASC X12N format.
